BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
ALOK BHATTACHARYYA, M.D.	)	File No. 12 2000 111662
Physician's and Surgeon's Certificate No. A 42257	)	
Respondent.	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on August 8, 2005.

IT IS SO ORDERED July 8, 2005.

MEDICAL BOARD OF CALIFORNIA

By: _____
Ronald L. Morton, M.D., Chair
Panel A
Division of Medical Quality

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ALOK K. BHATTACHARYYA, M.D. 1171 11th Street Lakeport, California 95453 Physician's and Surgeon's Certificate No. A 42257 Respondent.	Case No. 12 2000 111662 OAH No. N2003080219

PROPOSED DECISION

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings on November 3 through 5, and 8, 2004, in Oakland, California.

Lawrence A. Mercer, Deputy Attorney General, represented complainant.

Timothy J. Aspinwall, Esq., and John T. Kennedy, Esq., represented Alok K. Bhattacharyya, M.D., who was present.

Submission of the matter was deferred pending transcript preparation and receipt of written closing argument. Complainant's Closing Argument was received on April 15, 2005, and marked as Exhibit 25 for identification. Respondent's Closing Argument was received on April 29, 2005, and marked as Exhibit DD for identification. Complainant' Reply Brief was received on May 4, 2005, and marked as Exhibit 26 for identification. The case was submitted for decision on May 4, 2005.

FACTUAL FINDINGS

1. Ronald Joseph, former Executive Director of the Medical Board of California (Board), brought the Accusation solely in his official capacity.

2. On November 4, 1985, the Board issued Alok K. Bhattacharyya, M.D. (respondent) Physician's and Surgeon's Certificate No. A 42257. The certificate was current at all times pertinent to this matter. It would have expired on September 30, 2003, if not renewed. There has been no prior disciplinary action taken against this certificate.

3. Respondent is a board certified neurologist. He was certified as a diplomate of the American Board of Psychiatry and Neurology in November 1993. He did his medical training at the University of Calcutta, India, receiving his M.D. degree in 1971. He also received a doctorate in physiology from the same university in 1976. After coming to the United States he received licenses to practice medicine in California, Georgia, Maryland, Virginia and West Virginia. He also holds licenses to practice medicine in India and the United Kingdom. Respondent completed a residency in neurology at Howard University Hospital in June 1985. He worked as a neurologist and Chief of the Neurophysiology Laboratory at Logan General Hospital, Logan, West Virginia. He then moved to Lakeport, California, where he practiced as a neurologist in Lake and Mendocino Counties. Respondent now practices primarily in Fremont and Antioch, with some work in Ukiah and Lakeport. He is on the medical staff at Washington Hospital in Fremont, Sutter Delta Medical Center in Antioch, and Lakeside Hospital in Lakeport. He also has courtesy staff privileges at Mt. Diablo Hospital in Concord, and consulting staff privileges at Ukiah Medical Center.

Respondent is a member of the American Academy of Neurology. He is also a member of the clinical faculty, Department of Neurology, Stanford University Medical Center. Previously, he was an assistant professor in the Department of Pharmacology, Howard University. And before that he was a post doctoral fellow at Howard University under a grant from the National Cancer Institute and the National Institute of Mental Health. Respondent has authored a number of abstracts and papers, 17 that were published in the United States. Until recently, part of his work consisted of performing disability evaluations as a qualified medical examiner for the State of California. He was a consultative examiner with the Department of Social Services, but stopped doing these evaluations because of this Accusation.

4. Complainant contends that between 1996 and 2000, respondent performed cursory and deficient neurological examinations on five patients. The Accusation details a number of specific allegations that form the basis for complainant's belief that respondent's reports omitted essential history and examination findings. Complainant contends that respondent's reports offered clinical impressions which are not based on any documented findings and which overlooked key complaints and diagnoses. Complainant believes respondent is a physician whose "clinical practice is careless and haphazard from beginning to end and which warrants a probation, remedial education and monitoring to address the many deficiencies identified at the administrative hearings."

Respondent contends that his neurological examinations of the five patients were within the standard of care. He suggests that the medical experts differ primarily over whether a summarized record of a neurological examination is adequate and that there is a

range of acceptability, from very detailed reports to those that are more summarized. He believes that his more summarized reports are consistent for practicing physicians in a non-academic setting who have been practicing for many years. Respondent characterizes himself as a highly experienced physician who has learned to summarize reports. He notes that he has not been criticized for his reporting style by either the Department of Social Services or by the physicians who refer patients to him, and that any complaint against his practice was initiated by a single individual who specializes in representing disability applicants.

Patient No. 1 (P-1)

5. P-1 is an adult male who suffered severe head trauma on December 3, 1998, at which time he sustained an intracerebral hematoma and underwent surgery for evacuation of the hematoma and a partial modified frontal lobectomy. He was followed by neurologist Peter Glusker, M.D., who noted, in an evaluation performed on April 26, 1999, several problems dating from P-1's head injury including severe insomnia, electrical sensations in the area of his frontal scars, a mild facial droop and itching skin, leg discomfort, heartburn, jerking in his legs seeming to tie his bedclothes into a knot at night, daytime sleepiness, difficulty with concentration and memory, depression and crying easily. Dr. Glusker performed a neurological examination on April 26, 1999, diagnosing P-1 with postconcussion syndrome, gastroesophageal reflux disease, periodic limb movement disorder of sleep and depression.

P-1 had been a fabric designer prior to his head injury. He applied for Social Security disability and was referred by the Department of Social Services to respondent for a neurological evaluation. Respondent saw P-1 on April 13, 2000. P-1 completed a patient information form. Beyond personal and insurance information, the form asked whether the patient had any allergies, took any medication on a regular basis and to identify any such medications if he did. There was also a yes/no survey of body systems, asking the patient if he had problems in any of the ten specified areas. P-1 denied having allergies, listed five medications and identified having serious problems with his head, eyes, ear, nose throat (HEENT), bladder/kidneys, and nerves. Respondent did not obtain or review any of P-1's medical records, laboratory studies or test results. He obtained information on P-1's personal and medical history from the information form and from his interview with P-1 at the time of his evaluation.

6. Respondent conducted an examination of P-1. His entire examination findings are set forth below:

> Height: 5'9.5". Weight: 180 lb. Right-handed. Vital signs were stable. Awake, alert, oriented to three. Followed commands well. Speech fluent, hearing normal. No anomia. No right or left disorientation. Not confused or agitated. His present and past memory was fair. The retention span was 3/3. He was able to do simple calculation. No singer agnosia was noted. MMSE score was within normal limits.

HEENT: Normocephalic. Neck supple. Carotid 2+. JVD flat. No lymphadenopathy detected. Old craniotomy mark was noted on the right frontal side.

CRANIAL NERVES: Extraocular movements were full. PERRLA. Full visual fields. No facial weakness. Tongue and uvula midline. Gag and cough normal. No nystagmus. Fundi normal. No ataxia was seen. No involuntary movements present.

SENSORY EXAMINATION: Normal. All pulses 2+. No atrophy or fasciculation was seen. He had some pain in the left shoulder without any restriction in the range of motion. Mild lumbosacral tenderness was positive.

MOTOR EXAMINATION: Tone and power 5/5. Deep tendon reflexes 2+. Plantars flexor. Gait steady. Spine mobility showed restriction to forward flexion below the knee level.

Respondent found no focal neurological deficit on examination and under his clinical impressions noted a "[p]revious history of a head trauma followed by brain contusion, subdural hematoma in 1998 without any definite neurological deficit." He also noted a history of "seizure disorder, no further seizures at this time." In terms of physical limitations, he recommended that P-1 not walk on any uneven ground and noted that he had "some occasional postural limitation of bending, stooping, and crouching." He also recommended that P-1 avoid dangerous environments such as driving, fire, water and heights. Respondent found that P-1 was otherwise able to sit, stand, and walk during the eight hours of workdays with normal breaks and could lift or carry about ten pounds of weight frequently. He billed the Department of Social Services for a complete neurological examination.

7. P-1 was evaluated one week later on April 20, 2000, by Dr. Glusker for a neurological consultation to evaluate daytime sleepiness. P-1 also reported "continued awkwardness with his left arm and leg, sometimes hitting things, and sometimes being a little unstable with his gait. He also reports problems finding words, and focusing his attention sometimes." Dr. Glusker conducted a neurological examination that revealed information not noted in respondent's earlier findings. Specifically, a left upper extreme pronator drift was noted, and decreased rapid alternate movements with the left arm. Muscle stretch reflexes were normal in the right biceps, triceps and brachioradialis, but 1+ on the left in the homologous regions. Similarly, the right quadriceps and gastrocnemii were normal, with the left increased 1+. Dr. Glusker diagnosed P-1 with subtle left hemiparesis due to his head injury and possible obstructive sleep apnea and/or periodic limb movement disorder.

8. Accusation paragraphs 42A through 42L detail twelve matters in which respondent is alleged to have demonstrated an extreme departure from the standard of care

and/or lack of basic medical knowledge in his care and examination of P-1. They will be separately considered here.

a. 42A. Complainant contends that respondent failed to elicit and document a history of such things as basal skull fracture, severe sleep disorder, history of substance abuse, ongoing depression, level of education, attainments in work, current work capacity, mood, or any information about memory lapses. Respondent interviewed P-1 and was thereby limited to what P-1 told him. Respondent did not review P-1's medical records. There were inaccuracies in P-1's history. For example, by all accounts P-1 has a drinking problem and respondent noted that his history "was not suggestive for any alcohol or drug abuse or smoking." Yet it is clear that respondent relied primarily upon information supplied to him by P-1. P-1 denied any history of alcohol or drug abuse and stated that his head trauma was caused by an attempted mugging. The clinical records indicate that P-1 suffered a head injury following heavy alcohol intake. Respondent did not receive P-1's clinical records from the Department of Social Services or directly from any other source. In the absence of medical records respondent would not have known that P-1 had a basal skull fracture or a severe sleep disorder unless P-1 told him.

Nancy Sajben, M.D., testified as an expert witness on behalf of complainant. She is board certified by the American Board of Psychiatry and Neurology, with competence in adult neurology. Between 1983 and 1992, she served as assistant clinical professor, Department of Neurology, UCLA School of Medicine. She is currently in private practice in Santa Monica and Los Angeles, focusing her practice on pain medicine and neurology. Dr. Sajben notes that a complete neurological examination includes a comprehensive past medical history including medications, prior medical problems, previous injuries, surgeries and a social/psychological history. She would also include level of education, training, job function and family history.

Desmond Erasmus, M.D., testified as an expert witness on behalf of respondent. He is board certified and a diplomate of the American Board of Neurological Surgery. Dr. Erasmus notes that it is standard practice to use a patient questionnaire to elicit personal information such as drug/alcohol usage and smoking. He does not believe respondent's failure to have information about P-1's education attainment or current work capacity was an extreme departure from the standard of care, and he notes that respondent did test P-1's memory and found that his present and past memory was fair. Overall, Dr. Erasmus found no departure from the standard of care in the fact that respondent's report did not include any mention of basal skull fracture, severe sleep disorder, history of substance abuse, ongoing depression, level of education, attainment in work, or current work capacity.

Dr. Erasmus is persuasive on this point. In obtaining P-1's personal and medical history, respondent was limited to information supplied to him by the patient. There was no way respondent could have known more about the specifics of P-1's history short of having the medical records on hand and it was easy for him to miss elements of P-1's history when his focus was on the problems for which P-1 was referred to him. Respondent now intends

to use a more comprehensive patient questionnaire to elicit additional information for use in obtaining patient histories.

b. 42B. Complainant contends that respondent failed to perform a complete cranial nerve examination. The cranial nerve exam involves testing the function of all 12 sets of cranial nerves. Complainant alleges that respondent failed to specify whether he performed an examination on cranial nerves V, XI and XII. Dr. Erasmus notes that the fact that respondent made reference to "tongue and uvula midline. Gag and cough normal" indicates that cranial nerve V was tested. He further notes that cranial nerve XI was tested as indicated by respondent's reference to "neck supple." And Dr. Erasmus believes cranial nerve XII was examined because respondent looked at P-1's tongue and noted that his speech was "fluent."

Dr. Sajben opines that the cranial nerves could not have been tested as there were absent from respondent's findings certain abnormalities that a neurologist would expect to find in a post-frontal lobectomy patient, such as a facial droop evidencing damage to cranial nerve VII. Complainant also suggests that that Dr. Erasmus can do no more than speculate whether the cranial examination was performed, noting that cranial nerve V involves more than opening and closing the mouth, but tests facial sensation and the muscles of mastication. And for cranial nerve XI, Dr. Erasmus is speculating that P-1 would have had to turn his head for his neck to be described as supple, and that simply turning P-1's head would not amount to the flexion against the physician's resistance required for this test. Only this much is clear, respondent's cranial nerve examination findings do not document whether the cranial nerves were all tested. Dr. Erasmus opines that it is not a violation of the standard of care to not specifically document each and every cranial nerve tested by number. However, the standard of care does require that a full cranial nerve examination be performed and there is no documentation in respondent's records for P-1 that this was done. Unless a physician documents cranial nerve examination findings, a subsequent reviewer will be unable to tell whether each cranial nerve was tested or what information was provided by the test. Dr. Sajbean notes that in a patient such as P-1, cranial nerve examination is important because of the information obtained about the potential for further problems developing.

c. 42C. Complainant contends that respondent failed to perform a complete cerebellar examination and/or failed to specify whether the examination included finger-finger-nose or heel-knee-shin, rapid movement testing which is often slowed in patients with frontal lobectomy, or tandem gait or Romberg, tests of balance, despite P-1's problems with balance. Respondent's only notation is that no ataxia was seen. He testified that he did perform a cerebellar examination and that he asked P-1 to perform the finger-nose test and the heel-shin test. It would be standard of care to perform and document such an examination. Respondent failed to document this examination in his report.

d. 42D. Complainant contends that respondent failed to perform a complete sensory examination and/or failed to specify whether the examination included testing higher cortical release signs such as palmo-mental reflex, glabellar, jaw jerk and Hoffman reflexes, which may be impaired in head injury patients.

Respondent simply wrote that P-1's sensory examination was normal and Dr. Erasmus opines that this was within the standard of care. However, both Dr. Sajbean and Dr. Erasmus agree that respondent's report did not provide sufficient information to tell whether a full sensory examination was performed. The evidence is mixed on whether higher cortical release signs should be routinely tested for this type of patient.

e. 42E. Complainant contends that respondent failed to perform a sufficient mental status examination on P-1 by, among other things, failing to assess his mood; to document his numerical score on the mini mental status examination (MMSE); and to note and/or determine whether P-1 could spell a simple word forward and backwards, to understand proverbs, and to follow three step commands. Respondent's report indicates that a mental status examination was performed. Respondent reported that P-1's score on the MMSE was normal and Dr. Erasmus opines that it is within the standard of care to report a MMSE score as normal rather than to provide a numeric score. Dr. Sajben is critical of respondent's lack of detail, pointing out that scores should be reported so that they can be referred to and compared years down the road. The need for detail is also evident in respondent's difficulty in recalling anything that was not in his report. For example, he could not tell whether P-1's recall of 3/3 objects was after 5, 10 or fifteen minutes. He could not recall what calculation P-1 was able to perform. He believes that P-1's MMSE score was 30, yet this is suspect given that 30 is a perfect score. For these reason, respondent's documentation of the mental status examination on P-1 was deficient and not within the standard of care.

f. 42F. Complainant contends that respondent did not have P-1 remove his shoes for the examination, yet noted "plantars flexor" in his report. As part of testing, the sole of a patient's foot is stimulated in order to check for the Babinski response. Plantars flexor, toes curling downward, is a normal response. If the toes fan upward, a number of neurological disorders may be indicated. Respondent avers that he had P-1 remove his shoes to perform this test. It is impossible to perform the test otherwise. Complainant offered no evidence that respondent did not have P-1 remove his shoes for purposes of this particular test.

g. 42G. Complainant contends that respondent failed to obtain and review pertinent patient records. This was partially discussed above. (See Finding 8a.) Complainant believes it was incumbent upon respondent, as the evaluating neurologist, to examine P-1 and to compare P-1's condition as he found it to past examinations. Although the examination in this case was for purposes of making a disability determination, the medical experts agree that the standard of care for conducting a neurological examination is the same regardless of its purpose. While far from ideal, it was not uncommon for respondent to receive a request for examination without accompanying patient records. And Dr. Sajben acknowledged that respondent would not have been able to obtain patient records on his own without a patient's release, and that such records are usually provided directly to the agency requesting a disability evaluation, the Department of Social Services in this case, and not to the physician evaluator.[1] It was no a departure from the standard of care for respondent to perform the

[1] Robert Schoenfelder is an operations analyst with the Department of Social Services (DSS) and liaison with physician evaluators. He confirms that it is frequently the case that DSS has no medical records to provide the

neurological examination without having pertinent patient medical records available to him in this case.

h. 42H. Complainant contends that respondent failed to find that P-1 had increased reflexes on the left side, as observed by Dr. Glusker a week later on April 20, 2000. Respondent's motor examination does not document whether several important aspects of the motor examination, such as pronator drift or rapid alternating movement tests, were performed. Respondent offers no explanation of how P-1 could demonstrate this significant neurological deficit within a week after he made no abnormal findings. Respondent insists that he records any abnormal findings in his reports. There is no evidence that P-1's condition changed over this short period and Dr. Glusker attributed the left side hemiparesis to P-1's earlier head injury. Respondent should have found and documented this neurological deficit on his examination.

i. 42I. Complainant contends that respondent incorrectly stated that P-1 had no history of alcohol or drug abuse. Respondent relied upon information provided to him by P-1 and, as Dr. Erasmus noted, patients will often deny their history of drug and alcohol abuse when speaking to their physician. Without having other medical records available to him at the time he performed his evaluation, respondent had no information other than that provided to him by P-1. (See Finding 8a.)

j. 42J. Complainant contends that respondent failed to mention several highly relevant diagnoses such as intracerebral hematoma, right frontal lobectomy, skull fracture, post concussion syndrome, depression, alcohol abuse, periodic limb movements during sleep, severe sleep disorder, excessive daytime sleepiness, substance abuse, and cognitive dysfunction. When P-1 was referred by the Department of Social Services, reference was made to shoulder, neck and speech problems. As already noted, diagnoses such as skull fracture, intracerebral hematoma and right front lobectomy could not have been made without the test results or operative reports that were not available to respondent. P-1's sleep disorder was confirmed only after he saw respondent. On June 9, 2000, a sleep specialist, Jon F. Sassin, M.D., performed polysomnographic testing on P-1 that was abnormal due to severe sleep-related periodic limb movements. Dr. Glusker was asked to evaluate P-1's daytime sleepiness a week after respondent saw P-1, but it does not appear that such was a presenting complaint when he saw respondent.

Respondent's clinical impressions included: "History of seizure disorder, no further seizures at this time." In his history he noted that P-1 denied having seizures anymore. In fact, P-1 had no history of seizures. He was given Dilantin only as a seizure prophylaxis after his head injury. This medication was discontinued and respondent mistakenly assumed that he had a history of seizure disorder.

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medical examiner and that this occurs for a variety of reasons including "the applicant has no medical sources; the applicant has failed to recall or accurately include such medical sources on the application; we have ordered records but the medical sources have not replied or the reply from the medical providers is so delayed that we do not have any records to include at the time we order the examination from the Consultative Examiner."

k. 42K. Complainant contends that respondent found no abnormalities of gait and no ataxia, yet he prohibited P-1's walking on uneven ground and recommended that he avoid dangerous environments such as driving, fire, water and heights. Respondent notes that he was told that P-1 suffered from intermittent balance problems and on this basis he recommended that P-1 not walk on uneven surfaces to avoid falling. Respondent's history references the fact that P-1 has some "balance problems on the left side intermittently." Complainant notes that such restriction, after finding no ataxia, has little relation to examination findings and that P-1 was unfairly put at risk of losing government disability benefits and driving privileges. Respondent considered P-1's reported history in making these conservative recommendations. As to driving, his specific recommendation was that P-1 drive only with DMV permission, not that P-1 could not drive. Respondent's recommendations were not unreasonable under the circumstances.

l. 42L. Complainant contends that respondent billed his incomplete examination of P-1 as a complete neurological examination. Respondent notes that he has completed approximately 330 examinations for the Department of Social Services and has never been criticized for his billing practices. A letter from Robert Schoenfelder, operations analyst, Disability and Adult Programs Division, confirms this. Mr. Schoenfelder oversees respondent's work for the Department of Social Services and reports no problems with respondent's evaluations.

Patient No. 2 (P-2)

9. P-2 is an adult male who was referred to respondent by Robert B. Rushton, M.D. P-2's initial complaint to Dr. Rushton was that he had an episode where his left leg and left arm got numb and the numbness continued for 5 – 10 minutes before going away. He had another episode when his left leg had gone numb while watching television. P-2 also complained of a tremor in his left upper extremity and markedly decreased grip strength. In March 1999, P-2 presented to Dr. Rushton with left shoulder pain. He gave no history as to how this started. In fact, he had injured his shoulder at work but was afraid to disclose this fact for fear that he would lose his job. P-2 is slightly mentally retarded. An MRI of his shoulder was eventually ordered and a correct diagnosis of rotator cuff tear was made later that year. However, at the time he was seen by Dr. Rushton, the focus was on P-2's complaints of rotary tremor of his left arm and weakness in his left hand. Dr. Rushton thought it might have an anxiety/stress component, but wanted to first rule out any neurological problems and he referred him to respondent for this reason. Respondent rented an examination room in Dr. Rushton's office for once weekly examinations for 15 years. Respondent examined P-2 in Dr. Rushton's office on March 18, 1999.

Respondent prepared a report of his examination. P-2 complained of acute tremor on the left upper extremity and occasionally on the right since the first week of March 1999. He also complained of some numbness on the left hand more than the right. He admitted to experiencing significant stress and anxiety related to work. Respondent obtained a medical/personal history from P-2. Dr. Rushton was also available for consultation and the two did have discussions. Respondent's examination findings are set forth below:

EXAMINATION: Vital signs were stable. Awake, alert, oriented to three. Follows commands well. Speech fluent, hearing normal. No anomia. No right or left disorientation. Not confused or agitated.

HEENT: Normocephalic. Neck supple. Carotid 2+. JVD flat. No lymphadenopathy detected.

CRANIAL NERVES: Extraocular movements were full. PERRLA. Full visual fields. No facial weakness. Tongue and uvula midline. Gag and cough normal. Nor nystagmus. Fundi normal. No ataxia seen. Mild action tremor and occasional resting tremor on the left hand more than the right. No significant Bradykinesia or rigidity.

MOTOR EXAMINATION: Tone and power 5/5 on all muscle groups, on all limbs. Deep tendon reflexes 2+, equal bilateral. Plantars flexor. Gait steady with heel, toe, tandem walk.

Under respondent's clinical impressions he noted: "the possibility of any cervical radiculopathy vs. nerve entrapment syndrome vs. neuropathy or thoracic outlet pathology need to be ruled out. Associated possible action tremor. Associated anxiety and tension." He also recommended having an MRI scan of the brain, an EEG as well as a blood workup for any heavy metal and toxic screening.

10. Respondent did electromyography, nerve conduction velocity, and F-wave latency determination tests on both of P-2's upper extremities. His impression was mild abnormal nerve conduction velocity study in median nerve distribution on left upper extremity, suggestive for carpal tunnel pathology. However, no significant electromyographic abnormalities were detected.

Respondent administered an EEG to P-2 on March 24, 1999. His clinical interpretation was no definite paroxysmal features seen during drowsy and awake phase of recording and no definite focal features seen. He noted that this suggested history and clinical correlation. However, respondent did not prepare a second evaluation report to narrow the field of differential diagnoses after doing the EEG.

11. Dr. Rushton saw P-2 on March 18 and 26, 1999. On both occasion he noted that P-2 continued to have a rotary tremor and continuing weakness in his left hand. On examination, P-2's grip strength continued at a ratio of 1:4, left to right.

12. Accusation paragraphs 63A through 63H detail eight matters in which respondent is alleged to have demonstrated an extreme departure from the standard of care and/or lack of basic medical knowledge in his care and examination of P-2. They will be separately considered here.

a. 63A. Complainant contends that respondent's history fails to describe P-2's sensory symptoms, weakness, tremor, and numbness and fails to describe such things as the exact location of the sensory symptoms, what provoked and palliated them, whether they were associated with any particular time of day or activities, their frequency and duration, and whether they interfered with work or other activities.

It was established that respondent made only general references to P-2's tremors in his history and such is inadequate and below the standard of care. For example, Dr. Sajben notes that with respect to P-2's numbness, respondent fails to indicate how long did it happen, how long did it last, what provoked it, did it happen when P-2 was quiet, what was its duration, is it related to anything at all and was there pain associated with it. However, the context of respondent's examination must also be considered. Dr. Rushton was available at all times and present for part of the examination. It was performed in Dr. Rushton's office where respondent had immediate access to P-2's medical records. Dr. Erasmus opines that it is within the standard of care to have a more abbreviated history when the referring physician is present and when oral information is given to the referring physician. This was done here. Respondent examined P-2 and then performed EMG and nerve conduction studies. He and Dr. Rushton discussed the results and came to their conclusions together. Dr. Erasmus further notes that P-2 was referred to respondent for evaluation of a specific problem and that respondent focused upon and addressed this in his report. Dr. Sajben was not aware that Dr. Rushton was present for P-2's examination. Though respondent's history taking was inadequate, it was not an extreme departure from the standard of care given the context in which it was taken and recorded.

b. 63B. Complainant contends that respondent did not test range of motion of the cervical spine, shoulder, elbow, wrist or fingers and did not document where he performed the Tinel sign or if he did compression testing of the cervical spine. Respondent admits that he did not perform a muscular-skeletal examination. He notes that P-2 did not mention shoulder pain and that he did not find any restrictions of the joint on examination. Dr. Respondent did not indicate P-2's dominant hand and he did not report whether the positive findings on the Adson maneuver and the Tinel's sign were on the right or the left side. His failure to do so was below the standard of care.

c. 63C. Complainant contends that respondent failed to find the documented weakness in P-2's left hand. On March 18 and 26, 1999, Dr Rushton noted that P-2 continued to have weakness in his left hand and on examination, P-2's grip strength continued at a ratio of 1:4, left to right. In contrast, respondent found no weakness (tone and power 5/5) in all muscle groups on all limbs. Respondent's finding is particularly suspect given the fact that P-2 suffered an earlier rotator cuff tear, an injury that was confirmed on July 27, 1999. Respondent's failure to document left sided weakness upon examination fell below the standard of care.

d. 63D. Complainant contends that respondent failed to narrow the field of differential diagnoses. Respondent missed P-2 rotator cuff injury, noting instead that "the possibility of any cervical radiculopathy vs. nerve entrapment syndrome vs. neuropathy or

thoracic outlet pathology need to be ruled out." Respondent believes that if P-2 had disclosed his shoulder injury, it would have been easier to make a correct diagnosis. Although the differential diagnosis was not particularly useful, and omitted the correct rotator cuff injury diagnosis, it was not inconsistent with respondent's examination findings. Respondent also notes that the broad differential diagnosis included nerve entrapment syndrome and that this was supported by later electrical testing.

e. 63E. Complainant contends that respondent performed an EEG on P-2 without any indication for doing so. Respondent believes that the EEG was indicated on the basis that P-2 had both numbness and a tremor. Dr. Erasmus and Dr. Rushton also opine that an EEG is indicated in such cases to rule out a neurological basis for tremors. Dr. Sajben opines that an EEG has no relevance at all and was medically unnecessary. This is confirmed to a degree by Philip Wasserstein, M.D., who notes that optimally there is documented rationale for ordering an EEG, and that such is lacking in this case.

f. 63F. Complainant contends that respondent, after no abnormalities were detected on EEG, suggested a history/clinical correlation instead of either describing P-2's EEG as normal or making the correlation himself. This allegation was not established.

g. 63G. Complainant contends that respondent did not prepare a second evaluation report to narrow the field of differential diagnoses after doing the EEG despite his suggestion of history and clinical correlation. It was enough that respondent forwarded the EEG report to Dr. Rushton. A second report was not necessary in this case.

h. 63H. Complainant contends that respondent failed to obtain and review pertinent patient records. Respondent conducted the examination in Dr. Rushton's office. P-2's medical records were readily available to him. Importantly, Dr. Rushton was present and participated in the evaluation process. Dr. Erasmus notes that it is not uncommon for a referring physician to send a patient for a neurological or neurosurgical examination without the accompanying records. Given the above circumstances, it was not below the standard of care for respondent to have proceeded as he did in examining P-2.

Patient No. 3 (P-3)

13. P-3 is an adult male who was referred to respondent for a disability evaluation by the Federal Disability Determination Service. Respondent saw him on July 15, 1996. Respondent noted in the history that P-3 had significant pain all over the body including shoulders, neck, low back and hips for the last ten years. P-3 indicated that he was born with scoliosis and was not able to do his regular and customary work such as lifting, pushing or pulling. He reported being able to sit for a half hour, and to stand for less than an hour. He had not worked over the previous two years. P-3 denied any history of recent injury.

Respondent prepared an evaluation report reflecting that he took a history and did an examination that covered mental status, HEENT, cranial nerves, sensory and motor functioning. Respondent found no focal neurological deficit and found no definitive

evidence of any joint dysfunction. He concluded that P-3 had no neurological dysfunction and that his musculoskeletal system "does not show any significant pathology except some chronic syndrome and low back pain."

14. By declaration, P-3 reports that he was in respondent's examination room for no more than ten minutes. He avers that respondent did not have him remove any clothing, and that he did not remove his shoes and socks. He notes that respondent did not measure his extremities with a tape measure; that respondent tapped his knees with a rubber hammer but not his ankles or elbows; that respondent touched a tuning fork to his ankles, but did not touch him with any sharp object; that respondent asked him to bend over and touch his toes; that at no time during the examination did he lie down; that he did not grasp his legs with his hands; and that respondent did not ask him to walk on his heels or toes.

Based upon these facts, complainant contends that respondent conducted a cursory neurological examination. Complainant further alleges that respondent did not have P-3 remove his shoes for the examination, yet noted in his report that "plantars are flexor."

15. Respondent avers that he conducted a complete neurological examination as reflected in his report to the Federal Disability Service. The substantive portion of the report is only two pages in length. If P-3 is to be believed, respondent's actions in performing a ten minute neurological examination and reporting that he performed the Babinski test knowing that P-3 never removed his shoes is an extreme departure from the standard of care. However, the credibility of P-3 was not tested via cross examination. The evidence was by declaration and in that same declaration P-3 made similar criticisms of two other evaluators, Dr. H. Birk and Dr. S. McEntire. It is not clear whether these two are chiropractors or physicians. The state of the evidence, considered as a whole, does not allow for findings to be made on whether respondent performed only a cursory examination of P-3, or whether he performed the Babinski test as he reported.

Patient No. 4 (P-4)

16. P-4 is an adult male who was referred to respondent for a disability evaluation by the Department of Social Services. Respondent examined him on December 1, 1997. P-4 complained of recurrent blackout spells associated with drinking. He also had a history of seizure disorder, secondary to head trauma from a 1967 automobile accident. Respondent noted that P-4 had a history of hypertension, degenerative joint disease and possible benign prostatic hypertrophy. P-4 was taking Dilantin (200 mg), Ketoprofen, Cytotec and Buspar. Two months prior to seeing respondent, P-4 was seen by his primary care physician, Robert L. Hyde, M.D. Respondent did not obtain Dr. Hyde's record of this visit or any other of P-4's medical records, laboratory studies or test results. Respondent conducted a neurological examination and made the following findings:

> EXAMINATION: Vital signs are stable. Height: 5'7". Weight 185 lb. Awake, alert, oriented to three. Followed commands well. Speech

fluent, hearing normal. No anomia. No right or left disorientation. Not confused or agitated.

HEENT: Normocephalic. Neck supple. Carotid 2+. JVD flat. No lymphadenopathy detected.

CRANIAL NERVES: Extraocular movements are full. PERRLA. Full visual fields. No facial weakness. Tongue and uvula midline. Gag and cough normal. No nystagmus. Fundi normal. No ataxia is seen. No involuntary movements present.

SENSORY EXAMINATION: Normal. All pulses 2+. No atrophy or fasciculation is seen.

MOTOR EXAMINATION: Mild lumbosacral tenderness is positive. No joint restriction is seen. All joints' mobility is full in all directions. Spine mobility is full in all direction. Straight leg raising test is 75-80 degrees bilaterally. The patient is able to stand heel to toes. Tone and power 5/5. Deep tendon reflexes 2+. Plantars flexor. Gait steady with tandem walk.

Respondent found no neurologic deficits. In his clinical impression he noted a history of seizure disorder that he related to old head trauma, blackout spells related to chronic drinking and a history of degenerative joint disease with no obvious deformities of the joints, swelling or immobilities.

17. Complainant contends that respondent demonstrated an extreme departure from the standard of care and/or lack of basic medical knowledge in connection with his care and examination of P-4. Specific allegations are addressed below:

a. 89A. Complainant contends that respondent failed to take a complete history of P-4's pain failing to elicit and/or document information concerning joint disease or neurological weakness and dysfunction which may have impaired his ability to get up from a chair as noted in an earlier examination by Dr. Hyde. In fact, respondent's report does record a "history of degenerative joint disease including the spine." Respondent did not have Dr. Hyde's report but presumably the same information about P-4's difficulty getting out of a chair could have been reported to him just as P-4 had reported it to Dr. Hyde. P-4 was referred to respondent with primary complaints of recurrent blackout spells. Respondent properly focused upon this complaint, and not P-4's degenerative joint disease.

b. 89B. Complainant contends that respondent failed to elicit a detailed description of P-4's seizures, not mentioning whether the seizures involved loss of consciousness, when the last seizure occurred, how difficult it had been to bring them under control, or P-4's labyrinthine dysfunction. This allegation is sustained. Respondent only referenced the fact that P-4 denied any major seizure for a "long time" and this provided no useful information.

If a "long time" was less than one year, Dr. Erasmus agreed that this could be relevant. Respondent made no attempt to differentiate P-4's self-reported "blackouts" from seizures. Respondent's history regarding seizures is bereft of details and his clinical impression does no more than repeat P-4's reported history of seizure disorder related to old head trauma.

c. 89C. Complainant contends that respondent's sensory history for P-4 is incomplete, failing to mention in which part of the spine P-4 had degenerative joint disease, whether he experienced pain, and, if so, the location, severity and frequency of the pain and its consequences. Respondent does note "mild lumbosacral tenderness" and that spine mobility was full in all directions in his examination findings. Respondent adds that P-4 did not specifically complain about neck and back pain. He suggests that there was no reason why he, a neurologist, would have performed a joint or orthopedic examination. His failure to do so was not below the standard of care.

d. 89D. Complainant contends that respondent's history of P-4 gives no information about his education level, job history, current work capacity, mood, memory or fund of information. Dr. Erasmus is persuasive regarding neurologists not routinely including a patient's education, job history and related information in their reports. (See also Finding 8a.) Such information may be necessary when it relates to an underlying complaint, but that does not appear to be the case here where respondent correlated P-4's blackouts to his history of alcoholism. Respondent's failure to elicit additional information about P-4's education, job history, work capacity, mood or fund of information was not below the standard of care.

e. 89E. Complainant contends that respondent failed to obtain and review pertinent records. Respondent notes that neither Department of Social Services nor anyone else made P-4's clinical records available to him. As noted earlier and although not ideal, it was not an extreme departure from the standard of care for respondent to perform a neurological examination without having P-4's clinical records available to him. (See Finding 8g.)

f. 89F. Complainant contends that respondent's cerebellar examination was insufficient for an alcoholic and a patient with head trauma or labyrinthine dysfunction because the examination did not include, and/or he failed to specify, whether it included rapid finger movements, rapid alternating movements, finger-finger-nose, heel-knee-shin, tandem gait, or Romberg test. It is standard of care to document such testing and respondent failed to do so. His documentation of his cerebellar examination was below the standard of care.

g. 89G. Complainant contends that respondent's sensory examination was inadequate because he failed to test and/or failed to specify that he had tested the cranial nerve V for sensation at the three branches of his trigeminal nerve over the face, and did not do and/or indicate distal sensory testing. Respondent avers that he did test cranial nerves II – XII. Dr. Erasmus believes that cranial nerve V was tested because the masseter muscle was functioning as P-4 was able to open and close his mouth, and there were no complaints of numbness on his face. This was not documented and respondent's sensory examination of P-

4 therefore fell below the standard of care. Respondent notes that he has made changes in his practice and now separately details by number, each of the cranial nerves examined.

h. 89H. Complainant contends that respondent's mental status examination of P-4 was inadequate because he failed to assess and/or document, among other things, P-4's mood, memory recall by asking him to remember three objects in five minutes and having him subtract 7 serially from 100, P-4's ability to calculate, to spell a simple word forward and backwards, to explain proverbs and to follow three step commands. Respondent suggests in this case that there were no indications for exhaustive cognitive testing. He avers that he conducted a mental status examination that was tailored for this patient, noting that P-4 was awake, alert, oriented to three, followed commands well, speech was fluent, there was no right or left disorientation and he was not confused or agitated. Dr. Sajben disagrees, noting that a patient with a history of seizures and blackouts warrants a thorough neurological examination. She notes, for example, that patients with this history and who are alcoholic might have some alcoholic peripheral neuropathy distally in his feet. She also notes that such patients should at least have a mini-mental status examination to test for memory and fund of information. Respondent's mental status examination failed to include these elements and was below the standard of care.

i. 89I. Complainant contends that respondent failed to conduct and/or document a complete cranial nerves XI and XII. The matters set forth in Finding 8b also apply here. Respondent's cranial nerve examination findings do not document whether cranial nerves XI and XII were tested. The standard of care does require that a full cranial nerve examination be performed and there is no documentation in respondent's records for P-4 that this was done. Unless a physician documents cranial nerve examination findings, a subsequent reviewer will be unable to tell whether each cranial nerve was tested or what information was provided by the test.

j. 89J. Complainant contends that respondent did not have P-4 remove his shoes for the examination, yet noted "plantars flexor" in his report. This allegation was not established. Complainant offered no evidence that respondent did not have P-4 remove his shoes for purposes of this examination.

k. 89K. Complainant contends that P-4's blackout spells were related to his chronic drinking habit but did not mention how alcohol would affect P-4's seizure disorder and did not explain how he had differentiated P-4's presumptive alcoholic blackouts from his seizures. Respondent opined clearly that the blackouts correlated with P-4's drinking. However, he made no effort to differentiate the seizures from the blackouts other than to note they were secondary to head trauma. This allegation was sustained.

l. 89L. Complainant contends that P-4 did not mention a history of or make a recommendation of an alcohol rehabilitation program, social services support, or participation in a voluntary 12-step program. Respondent correctly notes that P-4 was referred to him by the Department of Social Services for a disability evaluation, not to get a recommendation for alcohol rehabilitation. It is generally understood that this is the

responsibility of a treating physician, not the disability evaluator. Although respondent could have made such a recommendation, the standard of care does not require him to do so.

m. 89M. Complainant contends that respondent failed to comment on the fact that P-4, who weighed 180 pounds and was 5'7" tall, was taking only 200 mg of Dilantin daily to control his seizures, rather than the 300 mg most adults of that size require. Respondent noted in his report that P-4 had not had any major seizure for a long time. He also notes that the majority of drugs, including Dilantin, metabolize through the liver and surmises that if P-4's liver function was compromised from alcohol consumption, the process of breaking down drugs would be slower, meaning a higher level of Dilantin could become toxic. Dr. Erasmus confirms that a patient that has begun to destroy his liver functions from alcohol consumption may be placed on a lower dose of Dilantin than what is normal. Respondent acknowledges, however, that there is no information indicating P-4 had any liver impairment.

n. 89N. Complainant contends that respondent billed his incomplete examination of P-4 as a complete neurological examination. As noted earlier, respondent has completed approximately 330 examinations for the Department of Social Services and has never been criticized for his billing practices. A letter from Robert Schoenfelder, operations analyst, Disability and Adult Programs Division, confirms this. Mr. Schoenfelder oversees respondent's work for the Department of Social Services and reports no problems with respondent's evaluations. It was not established that respondent's billing practices were improper.

Patient No. 5 (P-5)

18. P-5 is an adult male who was referred to respondent for a neurological examination by his treating physician, Michael A. Carnevale, M.D. Respondent saw him on May 29, 1997, and prepared a written evaluation report that same day. Respondent noted that P-5 presented with complaints of "some shaking spells predominantly during the sleep, the possibilities of any nocturnal seizure needs to be concerned." Respondent did not obtain or review any of P-5's medical records, laboratory studies or test results. Respondent conducted a neurological examination and made the following findings:

> EXAMINATION: Vital signs are stable. Over weight. Awake, alert, oriented to three. Followed commands well. Speech fluent, slight decrease of hearing noted. No anomia. No right or left disorientation. Not confused or agitated.
>
> HEENT: Normocephalic. Neck supple. Carotid 2+. JVD flat. No lymphadenopathy detected.
>
> CRANIAL NERVES: Extraocular movements are full. PERRLA. Full visual fields. No facial weakness. Tongue and uvula midline.

Gag and cough normal. No nystagmus. Fundi normal. No ataxia is seen. No involuntary movements present.

SENSORY EXAMINATION: Mild Dysesthesia on the lateral aspect of the left thigh and both hips noted. Minimal lumbosacral tenderness. Straight leg raising test is 65-70 degrees bilateral. All pulses 2+. No atrophy or fasciculation is seen.

MOTOR EXAMINATION: Tone and power 5/5 on all muscle groups, on all limbs. Deep tendon reflexes 2+, except the ankles 1-2. The patient is able to stand heel to toes. Spine mobility shows restrictions to forward flexion at the knee level. Plantars flexor. Gait steady with heel, toe, tandem walk.

Respondent noted the need to rule out possible nocturnal seizure disorder. He also raised concerns about possible lumbosacral radiculopathy versus neuropathy of the lower extremities. Respondent performed electrodiagnostic tests (electromyography) on both lower extremities, which did not indicate any significant pathology. He recommended that P-5 have an EEG done, which he performed on June 30, 1997. In the EEG report he wrote as indication for this test, "Possible seizure disorder." The EEG was non-revealing and he reported that no definite focal features or paroxysmal activities were noted. He suggested clinical correlation for a definitive diagnosis of epilepsy. Otherwise, respondent made no treatment recommendations and he did not prepare a second evaluation report for P-5.

19. Complainant contends that respondent demonstrated an extreme departure from the standard of care and/or lack of basic medical knowledge in connection with his care and examination of P-5. Specific allegations are addressed below:

a. 106A. Complainant contends that respondent failed to elicit and/or record P-5's weight, height, age, history of daytime somnolence, cognitive dysfunction, snoring, frequent night time awakenings, sinusitis, nasal fracture, or patency of nostril breathing. This allegation was sustained. Respondent made only general reference to the fact that P-5 was overweight with no specific information on his height, weight or age. In evaluating one with possible nocturnal seizures, additional information regarding night activities, perhaps obtained from P-5's wife or P-5's medical records, would be both useful and expected. Even though P-5 did not bring medical records with him, respondent could have obtained a more comprehensive history regarding P-5's "shaking spells" and other matters about which P-5 complained. Respondent's history in this case was below the standard of care.

b. 106B. Complainant contends that respondent did electrodiagnostic tests on both of P-5's lower extremities, including his asymptomatic right lower extremity, without any indication for doing so. Respondent ordered electrodiagnostic testing without stating any rationale for it. The failure to do so is a departure from the standard of care. It is not medically necessary to use electromyography (EMG) to diagnose meralgia parestetica, a condition of the cutaneous nerve often associated with obesity. Dr. Erasmus confirms that

electrodiagnostic testing was not necessary in this case, considering the mild nature of P-5's lumbosacral tenderness, ankle reflexes, bilateral hip dysthesia and numbness of the thighs. Even if respondent suspected that P-5 had a pinched nerve, an EMG on the right side was unnecessary in view of P-5's left thigh complaints. Respondent use of EMG was excessive medical treatment in this case and below the standard of care.

c. 106C. Complainant contends that respondent asserted in his June 30, 1997 EEG report that P-5 had a "history of seizure disorder" when he did not. Respondent acknowledges making this mistake. He notes that it should read "history of *possible* seizure disorder." His mistake was a departure from the standard of care.

d. 106D. Complainant contends that respondent did not prepare a second evaluation report after performing an EEG on P-5, and therefore failed to refine his diagnoses or further address P-5's night time shaking. Respondent did send a copy of the EEG report to Dr. Carnevale, together with his written report. Dr. Carnevale then took the next step of referring P-5 to a sleep laboratory for further diagnosis. While a second evaluation report would have been helpful, respondent's failure to prepare a second report was not below the standard of care.

e. 106E. Complainant contends that respondent did not have P-5 remove his shoes for the examination, yet noted "plantars flexor" in his report. P-5 did testify. He has no recollection whether respondent asked him to remove any article of clothing, including his shoes, or whether respondent tested his feet. He denies having an EMG study and avers that there was no testing of his lower extremities. P-5 avers that respondent's entire examination lasted less than five minutes. P-5 does not recall much detail regarding his examination by respondent and his estimate of the length of time that respondent spent during the examination is not reliable given the amount of information respondent apparently obtained and reported. It was not established that respondent failed to have P-5 remove his shoes for examination purposes.

f. 106F. Complainant contends that respondent failed to obtain and review pertinent patient records. P-5 brought no medical records with him. As noted earlier and although not ideal, it was not a departure from the standard of care for respondent to perform a neurological examination without having P-5's clinical records available to him. (See Finding 8g.)

Gross Negligence

20. Gross negligence has been defined as "the want of even scant care or an extreme departure from the ordinary standard of care." (*Franz v. Board of Medical Quality Assurance* (1982) 31 Cal.3d 124, 138; *Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196.) Dr. Sajben found most, if not all, departures from the standard of care in this case to be extreme, or grossly negligent. Her approach makes it difficult to gauge which departures from the standard of care were relatively serious and which were simple negligence. All practices that she deemed unacceptable in this case were also, in her opinion,

grossly negligent. This is not likely, particularly given the range of physician practices and variance in the level of detail that go into neurological evaluation reports. There is clearly certain baseline information required in every report and such matters have been discussed. But without further explanation of why Dr. Sajben found these matters to be more than simple departures from the standard of care, complainant has not met his burden of proving gross negligence by clear and convincing evidence to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

Complainant also failed to present clear and convincing evidence that respondent's conduct demonstrated incompetence, or "an absence of qualification, ability, or fitness to perform a prescribed duty or function." (*Pollack v. Kinder* (1978) 85 Cal.App.3d 833, 837.) Complainant concedes that respondent has "demonstrated an adequate knowledge base," and argues instead that he repeatedly failed to use this knowledge in a "methodical and professional manner."

Inaccurate/Inadequate Medical Records

21. Complainant contends that respondent failed to maintain adequate and accurate records with reference to the treatment of his patients. This allegation was sustained. The records relating to Patients 1 – 5 were considered and the examination findings for each patient are fully set out above. Respondent's medical evaluation reports for these patients are cursory and lacking in important detail. Histories are incomplete and examination findings for each patient are often summaries rather than documented observations. For example, while respondent may have conducted a full cranial nerve exam in a given case, his failure to document examination findings makes it impossible for subsequent reviewers to tell whether each cranial nerve was tested and what information was obtained. (See Findings 8b and 17i.) Respondent acknowledges that his examination findings are not well organized and that they were often under wrong headings. For example, sensory, cranial nerve, motor and other findings were "scattered" throughout the report rather than contained under each heading per standard practice. Respondent indicates that he his now changing the way he organizes evaluation reports, placing findings under appropriate headings and trying to make them more understandable.

Respondent notes that competent neurologists differ in the amount of detail they include in examination reports and that a short report does not mean that the examination has not been thorough. However, the point of maintaining adequate records is to memorialize examination findings for use by subsequent examiners. Although one can prepare abbreviated reports and still meet this requirement, respondent failed to do so in this case.

Excessive Treatment

22. Complainant contends that respondent's conduct constituted excessive use of diagnostic testing in the treatment of his patients. This allegation relates to Patients 2 and 5. The evidence is mixed for P-2. Respondent believes that the EEG was indicated on the basis that P-2 had both numbness and a tremor. Both Dr. Erasmus and Dr. Rushton agree that an

EEG is indicated in such cases to rule out a neurological basis for tremors. Dr. Sajben opines that an EEG has no relevance at all and was medically unnecessary and this was confirmed to a degree by Philip Wasserstein, M.D., who noted that optimally there is documented rationale for ordering an EEG. The different medical expert opinions having been considered, it was not established that respondent's use of EEG testing for P-2 constituted excessive use of diagnostic testing.

With regard to Patient 5, it was established that respondent's use of EMG was unnecessary. Diagnosis of meralgia parestetica could be made clinically without resort to nerve conduction studies. And even if respondent suspected that P-5 had a pinched nerve, an EMG on the right side was unnecessary in view of P-5's left thigh complaints. Respondent use of EMG was excessive medical treatment in the case of P-5. However, such practice was not part of a pattern of repeated acts of clearly excessive use of diagnostic testing to warrant disciplinary action under Business and Professions Code section 725.

False/Misleading Records and Claims

23. Complainant contends that respondent's conduct constitutes false, misleading or dishonesty in the making of medical records and/or insurance claims. This allegation was not established by the evidence. (See Findings 8l and 17n.)

Repeated Negligent Acts

24. Complainant contends that respondent's conduct in connection with his treatment of Patient 1 – 5 constituted repeated negligent acts. This allegation was sustained. Respondent repeatedly departed from the standard of care while performing neurological examinations on patients. (See Findings 8b, 8c, 8e, 8h, 12b, 12c, 17b, 17f, 17g, 17h, 17i, 17k, 19a, 19b and 19c.)

Cost Recovery

25. The Board has incurred the following costs in connection with the investigation and prosecution of this case:

Medical Board of California Investigative Services

Year	Hours[2]	Hourly Rate	Charges
2000	8	109.93	$ 879.44
2001/2002	54.25	110.84	6,013.07
2003/2004	3.75	111.38	416.67

[2] Approximately 5.5 hours were spent conducting interviews, 8.5 hours for record review, 1.5 hours for travel, 31.5 hours on report writing and 19 hours on document preparation, telephone, meetings, memos and letter writing.

An additional 40 hours @ $100 were spent by medical experts for reviewing and evaluating case-related materials, report writing, hearing preparation and examinations. Board investigative costs total $11,309.18.

Attorney General Costs

The costs of prosecution by the Department of Justice total $29,344.00. The cost certification has been reviewed and the time and charges are found to be in reasonable performance of tasks necessary for the prosecution of this case.[3] Investigative and prosecution costs total $40,653.18.

Disciplinary Considerations

26. Respondent believes that no discipline is warranted in this case, suggesting at most a citation and a fine for violation of provisions relating to his failure to maintain adequate records. However, it was established that respondent engaged in repeated negligent practices with regard to his reporting of neurological examinations of patients. A common pattern emerged. He prepared very cursory evaluation reports that failed to detail essential patient information and that contained plans and recommendations that were not supported by the documented history and examination findings. Respondent acknowledges that his reports of neurological evaluations should be better organized. He is in the process of developing new forms that would elicit more detailed patient histories and he avers that he now documents more medical information on his examination findings.

Complainant recommends that respondent be placed on probation and that he participate in a clinical education program such as the Physician Assessment and Clinical Education Program (PACE) at the University of California, San Diego School of Medicine. PACE has a clinical assessment component that allows for evaluation and identification of areas where a physician is in need of improvement and developing a plan to accomplish this. For example, PACE has a course on medical recordkeeping that it offers physicians who are found to be deficient in this area. The public interest would be served by placing respondent on probation on such terms that include his participation in a clinical education program.

[3] Though a breakout of hours for each task was not provided cost certifications detailed tasks including 1) conducting an initial case evaluation, 2) obtaining, reading and reviewing the investigative material and requesting further investigation, as needed; 3) drafting pleadings, subpoenas, correspondence, memoranda, and other case-related documents; 4) researching relevant points of law and fact; 5) locating and interviewing witnesses and potential witnesses; 6) consulting and/or meeting with colleague deputies, supervisory staff, experts, client staff, and investigators; 7) communicating and corresponding with respondent's counsel; 8) providing and requesting discovery; 9) preparing for and attending trial setting, status, prehearing and settlement conferences, as required, and 10) preparing for hearing.

LEGAL CONCLUSIONS

1. Under Business and Professions Code section 2234 the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes gross negligence, repeated acts of negligence, incompetence and the commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions or duties of a physician and surgeon. (Bus. & Prof. Code, § 2234, subds. (b) – (e).)

2. No cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in Finding 20. Complainant did not present clear and convincing evidence that respondent's conduct demonstrated gross negligence. Complainant also failed to demonstrate that respondent's actions constituted incompetence, essentially conceding that respondent has "demonstrated an adequate knowledge base." (Bus. & Prof. Code, § 2234, subd. (d).)

3. Cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in Finding 24. (Finding 24 incorporates Findings 8b, 8c, 8e, 8h, 12b, 12c, 17b, 17f, 17g, 17h, 17i, 17k, 19a, 19b and 19c.) Respondent's errors and omissions in connection with his examination, evaluation and care of patients constituted repeated negligent acts.

4. No cause for disciplinary action exists under Business and Professions Code sections 810, subdivision (a); 2261; and 2234, subdivision (e), by reason of the matters set forth in Finding 23. It was not established that respondent's conduct constituted false, misleading or dishonesty in making of medical records and/or insurance claims.

5. Cause for disciplinary action exists under Business and Professions Code sections 2234 and 2266, by reason of the matters set forth in Finding 21. Respondent failed to maintain adequate and accurate records relating to the provision of services to his patients.

6. Business and Professions Code section 725 provides, in part, that "[r]epeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon..." No cause for disciplinary action exists under Business and Professions Code sections 725 and 2234, by reason of the matters set forth in Finding 22. Although respondent's use of EMG was excessive medical treatment in the case of P-5, such practice was not part of a pattern of repeated acts of clearly excessive use of diagnostic testing to warrant disciplinary action under Business and Professions Code section 725.

7. Cost Recovery. Under Business and Professions Code section 125.3 the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act to pay the Board a sum not to exceed the

reasonable costs of the investigation and enforcement of the case. Requested costs total $40,653.18. (See Finding 25.)

The Board must not assess the full costs of investigation and prosecution when to do so will unfairly penalize a licensee who has committed some misconduct, but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed. The Board must consider the licensee's "subjective good faith belief in the merits of his or her position" and whether the licensee has raised a "colorable challenge" to the proposed discipline. (*Zuckerman* v. *Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45.) Such factors have been considered in this matter. Respondent had a good faith belief in the merits of his position and he raised a colorable challenge to accusation allegations. He successfully defended allegations against him based upon gross negligence, incompetence, excessive use of diagnostic procedures and false/misleading records and claims. An adjustment of costs to $25,000 would fairly and equitably accounts for these several factors.

8. The matters set forth in Finding 26 have been considered. It would not be contrary to the public interest to place respondent on probation at this time, the terms of which include participation in program such as PACE.

ORDER

Physician's and Surgeon's Certificate No. A 42257 issued to respondent Alok K. Bhattacharayya, M.D. is revoked pursuant to Legal Conclusions 3 and 5, separately and jointly. However, revocation is stayed and respondent is placed on probation for three (3) years upon the following terms and conditions:

1. Clinical Training Program. Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision, Accusation, and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its

recommendations for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

2. Notification. Prior to engaging in the practice of medicine respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days. This condition shall apply to any change in hospitals, other facilities or insurance carrier.

3. Supervision of Physician Assistants. During probation, respondent is prohibited from supervising physician assistants.

4. Obey All Laws. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

5. Quarterly Declarations. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

6. Probation Unit Compliance. Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such

addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b). Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

7. Interview with the Division or Its Designee. Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

8. Residing or Practicing Out-of-State. In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

9. Failure to Practice Medicine - California Resident. In the event respondent resides in the State of California and for any reason respondent

stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

10. Violation of Probation. Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. Cost Recovery. Within 90 calendar days from the effective date of the Decision or other period agreed to by the Division or its designee, respondent shall reimburse the Division the amount of $25,000 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve the respondent his obligation to reimburse the Division for its costs.

12. License Surrender. Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall

certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action.
If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

13. Probation Monitoring Costs. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

14. Completion of Probation. Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon completion successful of probation, respondent's certificate shall be fully restored.

DATED: June 10, 2005

JONATHAN LEW
Administrative Law Judge
Office of Administrative Hearings

H

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ALOK K. BHATTACHARYYA, M.D. 1171 11th Street Post Office Box 1692 Lakeport, California 95453 Physician's and Surgeon's Certificate No. A 42257 Respondent.	Case No. 12 2000 111662 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ronald Joseph ("complainant") brings this accusation solely in his official capacity as the Executive Director of the Medical Board of California.

2. On or about November 4, 1985, Physician's and Surgeon's Certificate No. A 42257 was issued by the board to Alok K. Bhattacharyya, M.D. ("Dr. Bhattacharyya" or "respondent") and at all times relevant to the charges brought in this accusation, this license has been in full force and effect. Unless renewed, it will expire on September 30, 2003.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California ("Medical Board" or "board"), under the authority of the following sections of the Business and Professions Code.[1]

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division of Medical Quality ("division") deems proper.

5. Section 2234 of the code provides in pertinent part that the division "shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

". . . ."

6. Section 810(a) provides, in part, that it constitutes unprofessional conduct for a health care professional to

"(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

"(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the

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1. All statutory references are to the Business and Professions Code unless otherwise indicated.

same, or to allow it to be presented or used in support of any false or fraudulent claim."

7. Section 2261 provides that "[k]nowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

8. Section 2266 provides that "failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. Section 725 provides, in part, that "[r]epeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon . . . ."

10. Section 125.3 of the Code provides, in part, that the board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

11. Welfare and Institutions Code section 14124.12 provides, in part, that a physician whose license has been placed on probation by the Medical Board shall not be reimbursed by Medi-Cal for "the type of surgical service or invasive procedure that gave rise to the probation."

12. At all times relevant to this matter, Dr. Bhattacharyya practiced medicine in California.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

PATIENT P-1[2]

13. On approximately December 3, 1998, patient P-1 suffered a head injury and was brought to the hospital with a decreasing level of consciousness. CT scans reflected subdural, subarachnoid, and intracerebral blood; air bubbles within the cerebral spinal fluid ("CSF") anteriorly; mass effect and midline shift; and fractures including a basal skull fracture across the petrous portion of the left temporal bone extending posteriorly into the left occipital region with another linear fracture high over the convexity on the right side (parietal).

14. P-1 underwent emergent surgery. A very large right frontal intracerebral hematoma and a small right frontal hematoma were evacuated and a partial modified frontal lobectomy was performed.

15. P-1 was transferred to North Coast Health Care Centers for rehabilitation on December 15, 1998 and was discharged home with 24 hour per day assistance on December 29, 1998.

16. At the time of discharge, P-1 was supervised/set-up for feeding, personal hygiene, dressing, toileting, and bathing. He required verbal cues and structured environment for completion. He was independent to modified independent for bed mobility. He was supervised for gait on all surfaces without an assistive device. He required verbal cues for attention.

17. Although P-1 had no history of seizures, he was given Dilantin as seizure prophylaxis after the head injury and continued on it until February 1998.

18. P-1 began treatment with neurologist Peter Glusker, M.D. on April 26, 1999. Dr. Glusker noted several problems dating from P-1's head injury–severe insomnia with inability to sleep, electrical sensations in the area of his frontal scars, a mild facial droop and itching skin, leg discomfort, heartburn, jerking in his legs seeming to tie his bedclothes into a

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2. The patients are referred to as P-1 through P-5 in this document to protect their privacy. Respondent may obtain their names through discovery.

knot at night, daytime sleepiness, difficulty with concentration and memory, depression, and crying easily.

19. Dr. Glusker noted that P-1 had a fifteen year history of alcoholism and that he had not used alcohol for 18 months at that time. He also noted that P-1 had had problems with amphetamine use in the past.

20. Dr. Glusker performed a neurological examination during the April 26, 1999 visit which included vital signs, carotid and cardiac auscultation, cranial nerves, motor, sensory, and reflex testing, noting that reflexes were 0 on the right compared to 1+ on the left. He diagnosed P-1 with postconcussion syndrome, gastroesophageal reflux disease, periodic limb movement disorder of sleep, and depression.

21. P-1 had been a fabric designer prior to his head injury but after the injury was unable to perform the job. He applied for Social Security Income and was required to have an neurological evaluation performed by respondent. P-1 saw respondent for that evaluation on April 13, 2000.

22. Respondent's history noted that P-1 had a history of head trauma in December 1998, that he had surgery in the right brain, and that a part of the right frontal lobe was removed due to "possible severe contusion and hematoma." He stated that P-1 admitted some memory and cognitive dysfunction since his head trauma, that he had no weakness or bladder and bowel dysfunction, and that he complained of some neck pain and balance problems on the left side intermittently and described a history of left side shoulder pain. Despite P-1's documented history of alcoholism and methamphetamine abuse, respondent stated that P-1's personal history was not suggestive for any alcohol or drug abuse. Despite the fact that P-1 had no history of seizures, respondent noted that P-1 "denied having seizures anymore."

23. Respondent did not obtain or review any of P-1's medical records, laboratory studies, or test results.

24. Respondent's history did not mention P-1's basal skull fracture, severe sleep disorder, history of substance abuse, on-going depression, level of education, attainments in work, current work capacity, mood, or any information about memory lapses.

25. Respondent's mental status examination reflected that P-1's vital signs were stable, that he was awake, alert, followed commands well, had no anomia or right or left disorientation, that he was not confused or agitated, his present and past memory was fair, his retention span was 3/3, he was able to do simple calculation, no singer agnosia was noted, and his Mini Mental Status Examination ("MMSE") was within normal limits.

26. Respondent's documentation of P-1's mental status examination was insufficient for a patient with cognitive complaints. Cognitive function may be impaired in a patient with alcoholism or head injury. Despite the fact that P-1's cognitive function was in question, he failed to assess his mood; failed to document his numerical score on the MMSE; failed to have him subtract 7 serially from 100; failed to specify which calculations were tested; and failed to note and/or determine whether P-1 could spell a simple word forward and backwards, understand proverbs, and follow three step commands.

27. Respondent's cranial nerve examination of P-1 was incomplete. He failed to assess sensation in cranial nerve V, trapezius and sternocleidomastoid muscle bulk and strength (cranial nerve XI), or strength and bulk of the tongue (cranial nerve XII).

28. Respondent's cerebellar examination of P-1 was incomplete. He commented only that P-1 had "no ataxia," but did not specify if this included testing finger-finger-nose or heel-knee-shin, rapid movement testing which is often slowed in patients with frontal lobectomy, or tandem gait or Romberg, tests of balance, despite P-1's problems with balance.

29. Respondent's sensory examination of P-1 was incomplete. He stated that P-1's sensory examination was normal without mentioning which modalities were tested; he did not mention testing higher cortical release signs such as palmo-mental reflex, glabellar, jaw jerk, and Hoffman reflexes, which may be impaired in head injury patients.

30. There was no mention of the specifics of his evaluation of P-1's cerebellar function or his sensory function, both of which may be impaired in alcoholic patients, or of his evaluation of P-1's cognitive function, which may be impaired in patients with epilepsy, alcoholism, or head injury.

31. Respondent's motor examination of P-1 revealed his deep tendon reflexes were 2+, plantars flexor, gait steady, and spine mobility restriction to forward flexion below the knee level.

32. Respondent failed to find contralateral hyper reflexia–reduced reflexes on P-1's left side–which was documented both before and after respondent's neurological examination of P-1 and found "plantars flexor" despite the fact that P-1 did not remove his shoes for the examination.

33. Respondent's clinical impression noted previous head trauma with brain contusion and subdural hematoma in 1998 without any focal neurological deficit; history of seizure disorder, no further seizures at this time; history of diabetes; history of chronic neck pain, but with full range of motion; and history of bipolar disorder.

34. Respondent made at least one inaccurate diagnosis–P-1 did not have a history of seizure disorder–and failed to mention several highly relevant diagnoses such as intracerebral hematoma, right frontal lobectomy, skull fractures, post concussion syndrome, depression, alcohol abuse, periodic limb movements during sleep, severe sleep disorder, excessive daytime sleepiness, substance abuse, and cognitive dysfunction.

35. Respondent's plan noted P-1 was able to sit, stand, and walk during the eight hours of workdays with normal breaks and could lift or carry about ten pounds of weight frequently. He stated that there was no restriction in manipulation including reaching, handling, feeling, grasping, and fingering frequently, and no limitation in visual and communicative skills. Although respondent noted no abnormalities of gait and no ataxia, he prohibited P-1's walking on uneven ground and recommended that he avoid dangerous environments such as driving, fire, water, and heights. He also noted some occasional postural limitation in bending, stooping, and crouching.

36. Despite the deficiencies noted above, respondent billed the Department of Social Services for a complete neurological examination.

37. One week after respondent's evaluation, on April 20, 2000, P-1 saw Dr. Glusker for a neurological consultation to evaluate excessive daytime sleepiness.

38. Dr. Glusker's history on the April 20, 2000 visit notes that P-1 reported awkwardness of his left arm and leg, sometimes hitting things, sometimes being a little unstable with his gait, and sometimes having problems finding words and focusing his attention.

39. Dr. Glusker performed a neurological examination and noted, among other things, a left upper extremity pronator drift, decreased rapid alternate movements with the left arm, normal muscle stretch reflexes of 0 in the right biceps, triceps, and brachioradialis, 1+ muscle stretch reflexes on the left in the homologous regions, normal right quadriceps and gastrocnmeii reflexes of 0, and 1+ left quadriceps and gastrocnmeii.

40. Dr. Glusker diagnosed P-1 with subtle left hemiparesis due to head injury and possible obstructive sleep apnea and/or periodic limb movement disorder. He referred P-1 to Jon F. Sassin, M.D., a sleep specialist, for an evaluation of his difficulties initiating and maintaining sleep.

41. On June 9, 2000, Dr. Sassin performed polysomnographic testing on P-1. P-1's polysomnogram was extremely abnormal because of severe sleep-related Periodic Limb Movements.

42. Respondent's certificate to practice medicine is subject to disciplinary action under Business and Professions Code section 2234, subsections (b) (gross negligence) and/or (d) (incompetence) in that his care of Patient P-1 demonstrated an extreme departure from the standard of care and/or lack of basic medical knowledge, including but not limited to the following respects:

A. Respondent failed to elicit and document a history of such things as basal skull fracture, severe sleep disorder, history of substance abuse, on-going depression, level of education, attainments in work, current work capacity, mood, or any information about memory lapses, as more particularly alleged above;

B. Respondent failed to perform a complete cranial nerve examination and/or failed to specify whether the examination assessed sensation in cranial nerve V, trapezius and sternocleidomastoid muscle bulk and strength (cranial nerve XI), or strength and bulk of the tongue (cranial nerve XII), as more particularly alleged

above;

C. Respondent failed to perform a complete cerebellar examination and/or failed to specify whether the examination included finger-finger-nose or heel-knee-shin, rapid movement testing which is often slowed in patients with frontal lobectomy, or tandem gait or Romberg, tests of balance, despite P-1's problems with balance, as more particularly alleged above;

D. Respondent failed to perform a complete sensory examination and/or failed to specify whether the examination included testing higher cortical release signs such as palmo-mental reflex, glabellar, jaw jerk, and Hoffman reflexes, which may be impaired in head injury patients, as more particularly alleged above;

E. Respondent failed to perform a sufficient mental status examination on P-1 by, among other things, failing to assess his mood; to document his numerical score on the MMSE; and to note and/or determine whether P-1 could spell a simple word forward and backwards, to understand proverbs, and to follow three step commands, as more particularly alleged above;

F. Respondent did not have P-1 remove his shoes for the examination yet noted "plantars flexor" in his report, as more particularly alleged above;

G. Respondent failed to obtain and review pertinent patient records, as more particularly alleged above;

H. Respondent failed to find that P-1 had reduced reflexes on the left side, as more particularly alleged above;

I. Respondent incorrectly stated that P-1 had no history of alcohol or drug abuse, as more particularly alleged above;

J. Respondent failed to mention several highly relevant diagnoses such as intracerebral hematoma, right frontal lobectomy, skull fractures, post concussion syndrome, depression, alcohol abuse, periodic limb movements during sleep, severe sleep disorder, excessive daytime sleepiness, substance abuse, and

cognitive dysfunction, as more particularly alleged above;

K. Respondent found no abnormalities of gait and no ataxia, yet he prohibited P-1's walking on uneven ground and recommended that he avoid dangerous environments such as driving, fire, water, and heights, as more particularly alleged above;

L. Respondent billed his incomplete examination of P-1 as a complete neurological examination, as more particularly alleged above.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

PATIENT P-2

43. Patient P-2 was seen by his primary care physician, Robert Rushton, M.D., on March 4, 1999 complaining of right foot pain and numbness in his left arm and leg.

44. Dr. Rushton noted that P-2 had an episode of numbness of the whole left leg and left arm for five to ten minutes three days earlier and, at the same time, was close to passing out and that the week before his left leg had gone numb while watching television.

45. Upon examination Dr. Rushton found that P-2's grip strength was weak in both hands but markedly weaker in his left hand and that he developed a tremor when attempting to produce a good grip.

46. Dr. Rushton's impression was new onset tremor and weakness in the left upper extremity.

47. Dr. Rushton referred P-2 to respondent for a neurology consultation.

48. Respondent saw P-2 for an evaluation on March 18, 1999. His report noted that P-2 presented with a complaint of acute tremor on the left upper extremity and occasionally on the right since the first week of March.

49. Respondent did not obtain or review any of P-2's medical records, laboratory studies, or test results.

50. Respondent's history fails to describe P-2's sensory symptoms, weakness, tremor, and numbness associated with a feeling that he might pass out. In fact, respondent's

history states "[n]o weakness of any extremities."

51. Respondent's history failed to describe the location of sensory symptoms, exactly which fingers or which side of the hand they were on, what provoked and palliated the symptoms, whether they were associated with any particular time of day or activities, their frequency and duration, whether they interfered with activities such as work, heavy lifting, coughing or sneezing, or holding hot coffee, and other factors essential to making a diagnosis and to correlate with any testing done on P-2.

52. Respondent's mental status examination reflected that P-2's vital signs were stable, that he was awake, alert, oriented to three, followed commands well, his speech was fluent, his hearing normal, he had no anomia, no right or left disorientation, and he was not confused or agitated.

53. Respondent found a mild action tremor and occasional resting tremor on the left hand more than right with no significant bradykinesia or rigidity. Dysesthesia was noted on the hands. He also noted "questionable Tineal [sic] sign" and Adson maneuver. The report does not document where respondent performed the Tinel sign or if he did compression testing of the cervical spine. Respondent found no weakness in any of P-2's extremities.

54. Respondent did not test range of motion of the cervical spine, shoulder, elbow, wrist, or fingers.

55. Respondent's impression, based on P-2's history and neurological evaluation, was that the possibility of any cervical radiculopathy vs. nerve entrapment syndrome vs. neuropathy or thoracic outlet pathology needed to be ruled out, and that there was associated possible action tremor, and associated anxiety and tension. Respondent should have narrowed the field of differential diagnoses by doing a complete and appropriate history and examination.

56. Respondent recommended an MRI of the brain, blood workup for heavy metal and toxic screening, EEG testing, Inderal, 10 mg three times a day, and Ativan, 1 mg every 12 hours.

57. Respondent's history provided no indication for heavy metal and toxicology screening.

58. Respondent did electromyography, nerve conduction velocity, and F-wave latency determination tests on both of P-2's upper extremities. His impression was mild abnormal nerve conduction velocity study in median nerve distribution on left upper extremity, suggestive for carpal tunnel pathology but no significant electromyographic abnormalities were detected. Although he said this suggested clinical correlation, his history was inadequate to accomplish such correlation.

59. On March 18, 1999, Dr. Rushton noted that he saw P-2 with respondent. He stated that P-2 continued to have a tremor and weakness in his hand and that, on examination, his grip strength continued at a ratio of one to four, left to right.

60. Neither respondent's history nor examination gave any indication for EEG testing. Nonetheless, on March 24, 1999, respondent administered an EEG to P-2. His clinical interpretation was no definite paroxysmal features seen during drowsy and awake phase of recording and no definite focal features seen. He noted that this suggested history and clinical correlation. His history, however, is so deficient that clinical correlation would be impossible.

61. Despite his suggestion of history and clinical correlation, respondent did not prepare a second evaluation report to narrow the field of differential diagnoses after doing the EEG.

62. On March 26, 1999, Dr. Rushton noted that, on examination, P-2 had continuing weakness in his left hand, 1:4, with a rotary tremor as soon as he tried to exert a grip.

63. Respondent's certificate to practice medicine is subject to disciplinary action under Business and Professions Code section 2234, subsections (b) (gross negligence) and/or (d) (incompetence) in that his care of Patient P-2 demonstrated an extreme departure from the standard of care and/or lack of basic medical knowledge, including but not limited to the following respects:

A. Respondent's history fails to describe P-2's sensory symptoms, weakness, tremor, and numbness and fails to describe such things as the exact location of the sensory symptoms, what provoked and palliated them, whether they were associated with any particular time of day or activities, their frequency and

duration, and whether they interfered with work or other activities, as more particularly alleged above;

B. Respondent did not test range of motion of the cervical spine, shoulder, elbow, wrist, or fingers and did not document where he performed the Tinel sign or if he did compression testing of the cervical spine, as more particularly alleged above;

C. Respondent failed to find the documented weakness in P-2's left hand, as more particularly alleged above;

D. Respondent failed to narrow the field of differential diagnoses, as more particularly alleged above.

E. Respondent performed an EEG on P-2 without any indication for doing so, as more particularly alleged above;

F. Respondent stated that no significant electromyographic abnormalities were detected on the EEG and that this suggested history and clinical correlation instead of either describing P-2's EEG as normal or making the correlation himself, as more particularly alleged above;

G. Respondent did not prepare a second evaluation report to narrow the field of differential diagnoses after doing the EEG despite his suggestion of history and clinical correlation, as more particularly alleged above;

H. Respondent failed to obtain and review pertinent patient records, as more particularly alleged above.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

PATIENT P-3

64. Respondent's consultation report states that patient P-3 was referred to him by the Federal Disability Determination Service for a disability evaluation. Respondent saw P-3 on July 15, 1996.

65. P-3 complained that for the past ten years he had experienced significant

pain all over his body including his shoulders, neck, low back, and hips.

66. Respondent's entire neurological examination lasted ten minutes or less and respondent did not have P-3 remove his clothing or shoes for the examination.

67. Respondent prepared an evaluation report reflecting that, despite the brevity of the evaluation, he took a history and did mental status, HEENT, cranial nerve, sensory, and motor examinations.

68. Despite the fact that P-3 did not remove his shoes for the evaluation, respondent noted in his report that "plantars are flexor."

69. Respondent's certificate to practice medicine is subject to disciplinary action under Business and Professions Code section 2234, subsections (b) (gross negligence) and/or (d) (incompetence) in that his care of Patient P-3 demonstrated an extreme departure from the standard of care and/or lack of basic medical knowledge, including but not limited to the following respects:

A. Respondent conducted a cursory neurological examination on P-3, as more particularly alleged above;

B. Respondent did not have P-3 remove his shoes for the examination yet noted in his report that "plantars are flexor," as more particularly alleged above.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

PATIENT P-4

70. Respondent's consultation report states that patient P-4 was referred to him by the Department of Social Service for a disability evaluation with a complaint of recurrent blackout spells when he drinks alcohol. Respondent saw P-4 on December 1, 1997.

71. Two months before this consultation, P-4 was seen by his primary care physician, Robert L. Hyde, M.D. Dr. Hyde listed diagnoses of post-traumatic epilepsy; degenerative arthritis, multiple joints, including lumbosacral spine and bilateral knees; chronic alcoholism; benign prostatic hypertrophy; and chronic labyrinth dysfunction, probably post traumatic. He noted that P-4 had difficulty arising from the chair.

72. Respondent did not obtain Dr. Hyde's record of this visit or any of P-4's medical records, laboratory studies, or test results.

73. Respondent noted in his history that P-4 took five to eight alcoholic drinks at times but had cut down recently, that he had been in an auto accident in 1967 followed by a head injury and subsequent seizure disorder for which he was taking 200 mg of Dilantin daily, and that he denied having any major seizure for "a long time." He noted that P-4 had a history of hypertension but was not taking medication for it, had a history of degenerative joint disease including the spine, and had possible benign prostatic hypertrophy. Respondent stated that P-4 denied any speech, vision, and swallowing problems; any weakness of extremities; any bladder or bowel dysfunction; and any history of recent fall, trauma, or injury.

74. Respondent failed to comment on the fact that P-4, who weighed 180 pounds and was 5' 7" tall, was taking only 200 mg of Dilantin daily to control his seizures rather than the 300 mg which most adults of that size require.

75. Respondent failed to take a complete history of P-4's pain. He did not elicit and/or document information concerning joint disease or neurological weakness and dysfunction which may have impaired his ability to get up from a chair as described in Dr. Hyde's notes.

76. Respondent failed to elicit a detailed description of P-4's seizures. His report does not, for example, mention whether P-4's seizures involved loss of consciousness or secondary generalized tonic-clonic movements, whether P-4 had any warning before the seizure or any symptoms after, and whether he had any resultant cognitive impairment. He did not elicit when the last seizure occurred or how difficult it had been for P-4 to bring them under control. He failed to mention the labyrinthine dysfunction which may have been a seizure.

77. Respondent's history mentioned that P-4 had degenerative joint disease including the spine but failed to mention which part of the spine (cervical, thoracic, or lumbar), whether P-4 experienced pain and, if so, the location, severity, and frequency of the pain, whether the pain impaired function, and, if it did, in what ways.

78. Respondent's history of P-4 gives no information about his education

level, job history, current work capacity, mood, memory, or fund of information.

79. Respondent's mental status examination reflected that P-2's vital signs were stable, that he was awake, alert, oriented "to three", followed commands well, his speech was fluent, his hearing normal, he had no anomia, no right or left disorientation, and he was not confused or agitated. Respondent did not document testing memory recall by asking P-4 to remember three objects in five minutes and subtract 7 serially from 100; testing P-4's ability to calculate; having P-4 spell a simple word forward and backwards, explain proverbs, and follow three step commands. He failed to assess P-4's mood and fund of information.

80. Respondent's cerebellar examination was insufficient for an alcoholic and a patient with head trauma or labyrinthine dysfunction. He noted only ataxia but failed to mention results of rapid finger movements, rapid alternating movements, finger-finger-nose, heel-knee-shin, tandem gait, or Romberg test (a test of balance).

81. Respondent stated P-4's sensory examination was normal without mentioning which modalities were tested. He did not indicate if cranial nerve V was tested for sensation at the three branches of his trigeminal nerve over the face and did not indicate distal sensory testing.

82. Respondent's cranial nerve examination of P-4 was incomplete. He failed to note trapezius and sternocleidomastoid muscle bulk and strength (cranial nerve XI) and strength and bulk of the tongue (cranial nerve XII).

83. Respondent noted that P-4's spine mobility was full in all directions but did not describe his lumbar range of motion in degrees or indicate how far he was able to touch his fingers on forward bending and side bending.

84. Despite the fact that P-4 did not remove his shoes for the evaluation, respondent noted "plantars flexor" in his report.

85. Respondent's clinical impression was that P-4 had no focal neurological deficit. He noted that P-4 had a history of seizure disorder related to the old head trauma; chronic alcoholism and blackout spells; and a history of degenerative joint disease without any obvious restriction of any joints, swelling, and mobility. He did not correlate objective evidence

with the patient history in formulating his conclusions.

86. Under "plan," respondent noted that P-4's seizure disorder was well controlled at the present, that his blackout spells were related to his chronic drinking habit, and that he had no obvious deformities of the joints. Respondent did not mention how alcohol would affect P-4's seizure disorder and did not explain how he had differentiated P-4's presumptive alcoholic blackouts from his seizures.

87. Respondent did not mention a history of or make a recommendation of an alcohol rehabilitation program, social services support, or participation in a voluntary 12-step program.

88. Despite the deficiencies noted above, respondent billed the Department of Social Services for a complete neurological examination.

89. Respondent's certificate to practice medicine is subject to disciplinary action under Business and Professions Code section 2234, subsections (b) (gross negligence) and/or (d) (incompetence) in that his care of Patient P-3 demonstrated an extreme departure from the standard of care and/or lack of basic medical knowledge, including but not limited to the following respects:

A. Respondent failed to take a complete history of P-4's pain failing to elicit and/or document information concerning joint disease or neurological weakness and dysfunction which may have impaired his ability to get up from a chair as noted by Dr. Hyde, as more particularly alleged above

B. Respondent failed to elicit a detailed description of P-4's seizures, not mentioning, for example, whether the seizures involved loss of consciousness, when the last seizure occurred, how difficult it had been to bring them under control, or P-4's labyrinthine dysfunction, as more particularly alleged above;

C. Respondent's sensory history for P-4 is incomplete, failing to mention, for example, in which part of the spine (cervical, thoracic, or lumbar) P-4 had degenerative joint disease, whether he experienced pain, and, if so, the location, severity, and frequency of the pain and its consequences, as more particularly

alleged above.

D. Respondent's history of P-4 gives no information about his education level, job history, current work capacity, mood, memory, or fund of information, as more particularly alleged above;

E. Respondent failed to obtain and review pertinent patient records, as more particularly alleged above;

F. Respondent's cerebellar examination was insufficient for an alcoholic and a patient with head trauma or labyrinthine dysfunction because the examination did not include and/or he failed to specify whether it included rapid finger movements, rapid alternating movements, finger-finger-nose, heel-knee-shin, tandem gait, or Romberg test, a test of balance, as more particularly alleged above;

G. Respondent's sensory examination was inadequate because he failed to test and/or failed to specify that he had tested the cranial nerve V for sensation at the three branches of his trigeminal nerve over the face and did not do and/or indicate distal sensory testing, as more particularly alleged above;

H. Respondent's mental status examination of P-4 was inadequate because he failed to assess and/or document, among other things, P-4's mood; P-4's memory recall by asking him to remember three objects in five minutes and having him subtract 7 serially from 100; P-4's ability to calculate, to spell a simple word forward and backwards, to explain proverbs, and to follow three step commands, as more particularly alleged above;

I. Respondent failed to conduct and/or document a complete cranial nerve examination of P-4--trapezius and sternocleidomastoid muscle bulk and strength (cranial nerve XI) and strength and bulk of the tongue (cranial nerve XII) are not mentioned, as more particularly alleged above;

J. Respondent did not have P-4 remove his shoes for the examination yet noted "plantars flexor" in his report, as more particularly alleged above;

K. Respondent noted that P-4's blackout spells were related to his chronic drinking habit but did not mention how alcohol would affect P-4's seizure disorder and did not explain how he had differentiated P-4's presumptive alcoholic blackouts from his seizures, as more particularly alleged above;

L. Respondent did not mention a history of or make a recommendation of an alcohol rehabilitation program, social services support, or participation in a voluntary 12-step program, as more particularly alleged above;

M. Respondent failed to comment on the fact that P-4, who weighed 180 pounds and was 5' 7" tall, was taking only 200 mg of Dilantin daily to control his seizures rather than the 300 mg which most adults of that size require, as more particularly alleged above;

N. Respondent billed his incomplete examination of P-4 as a complete neurological examination, as more particularly alleged above.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

PATIENT P-5

90. Patient P-5 sought treatment from Michael A. Carnevale, M.D. on June 13, 1995. Dr. Carnevale's chart notes for that visit reflect that P-5 had been fired from two jobs for being "too slow" and that he might have a learning disability and/or ADD. The notes reflect that P-5's wife reported that he stared into space a lot. A CT scan and a number of laboratory tests were ordered.

91. In the spring of 1997, Dr. Carnevale referred P-5 to respondent for a neurological examination. The examination was performed on May 29, 1997. Respondent's consultation report for P-5 states that he was referred for a complaint of shaking spells predominantly during sleep and that "possibilities of any nocturnal seizure needs to be concerned." He reported that P-5 denied having this problem during the daytime.

92. Respondent did not obtain or review any of P-5's medical records, laboratory studies, or test results.

93. Respondent stated in his history that P-5 complained of some numbness on the left thigh with some hip discomfort. He noted that P-5 was overweight but did not record his weight or height. He also failed to document his age.

94. Respondent also noted in his history that P-5 denied tongue biting, urinary incontinence, or history of meningitis or encephalitis and that he had no weakness of any extremities, no bladder or bowel problems, no history of fall, trauma, or head injury.

95. Respondent failed to elicit P-5's history of daytime somnolence and cognitive dysfunction or the fact that he snored and awakened frequently during the night as confirmed by polysomnogram on July 14, 1997, just over a month after respondent's evaluation.

96. Respondent's history also failed to include such pertinent matters as sinusitis, nasal fracture, or patency of nostril breathing.

97. Respondent's mental status examination reflected that P-5's vital signs were stable, that he was overweight, awake, alert, oriented to three, followed commands well, his speech was fluent, his hearing slightly decreased, he had no anomia, no right or left disorientation, and he was not confused or agitated. His characterization of P-5's hearing loss as slight was erroneous. In fact, P-5 had a serious hearing loss.

98. Respondent's examination of P-5 revealed mild dysesthesia on the lateral aspect of the left thigh and both hips, minimal lumbosacral tenderness, and restriction of the spine "to forward flexion at the knee level."

99. Despite the fact that P-5 did not remove his shoes for the evaluation, respondent noted "plantars flexor" in his report.

100. Respondent's clinical impression was possible nocturnal seizure disorder and he stated he wanted to rule out any lumbosacral radiculopathy vs. neuropathy of lower extremities.

101. With no indication for such testing, respondent did electrodiagnostic tests on both of P-5's lower extremities, including his asymptomatic right lower extremity. He found normal electromyography, nerve conduction velocity, and F-Waves of both lower extremities.

102. Under "plan" in his report, respondent noted that the electrodiagnostic

testing did not reveal any significant pathology. Respondent failed to make the simple and common bedside diagnosis of meralgia paresthetica noting only that he believed that P-5's problems ***might be*** related to meralgia paresthetica on the left lower extremity and that some weight loss might be helpful. He recommended an EEG.

103. Respondent administered an EEG test to P-5 on June 30, 1997. In his Introduction to the EEG report, respondent incorrectly asserted that P-5 had a "history of seizure disorder."

104. Respondent found no abnormalities on the EEG and suggested clinical correlation for definitive diagnosis of epilepsy.

105. Respondent did no further testing and made no treatment recommendations. He failed to incorporate the EEG results in a second evaluation report and, thus, failed to diagnose or further address P-5's shaking spells.

106. Respondent's certificate to practice medicine is subject to disciplinary action under Business and Professions Code section 2234, subsections (b) (gross negligence) and/or (d) (incompetence) in that his care of Patient P-5 demonstrated an extreme departure from the standard of care and/or lack of basic medical knowledge, including but not limited to the following respects:

A. Respondent failed to elicit and/or record P-5's weight, height, age, history of daytime somnolence, cognitive dysfunction, snoring, frequent night time awakenings, sinusitis, nasal fracture, or patency of nostril breathing, as more particularly alleged above;

B. Respondent did electrodiagnostic tests on both of P-5's lower extremities, including his asymptomatic right lower extremity, without any indication for doing so, as more particularly alleged above;

C. Respondent asserted in his June 30, 1997 EEG report that P-5 had a "history of seizure disorder" when he did not, as more particularly alleged above;

D. Respondent did not prepare a second evaluation report after performing an EEG on P-5 and therefore failed to refine his diagnoses or further address P-5's

night time shaking, as more particularly alleged above;

E. Respondent did not have P-5 remove his shoes for the examination yet noted "plantars flexor" in his report, as more particularly alleged above;

F. Respondent failed to obtain and review pertinent patient records, as more particularly alleged above.

SIXTH CAUSE FOR DISCIPLINE

(Inaccurate/Inadequate Medical Records)

107. Complainant incorporates the factual allegations of each of the above causes for discipline in this, the Sixth Cause for Discipline as though fully set forth herein.

108. Respondent's conduct constitutes the failure to maintain adequate and accurate records with reference to the treatment of his patients, and therefore cause for discipline exists pursuant to sections 2266 and 2234 of the Code.

SEVENTH CAUSE FOR DISCIPLINE

(Excessive Treatment)

109. Complainant incorporates the factual allegations of the first through the fifth causes for discipline in this, the Seventh Cause for Discipline as though fully set forth herein.

110. Respondent's conduct constitutes excessive use of diagnostic testing in the treatment of his patients, and therefore cause for discipline exists pursuant to sections 725 and 2234 of the Code.

EIGHTH CAUSE FOR DISCIPLINE

(False/Misleading Records and Claims)

111. Complainant incorporates the factual allegations of the first through the fifth causes for Discipline in this, the Eighth Cause for Discipline as though fully set forth herein.

112. Respondent's conduct constitutes false, misleading or dishonesty in the making of medical records and/or insurance claims, and therefore cause for discipline exists pursuant to sections 810(a), 2261 and 2234(e) of the Code.

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NINTH CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

113. Complainant incorporates the factual allegations of the first through the fifth causes for Discipline in this, the Ninth Cause for Discipline as though fully set forth herein.

114. Respondent's conduct constitutes repeated negligent acts and therefore cause for discipline exists pursuant to section 2234(c) of the Code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality of the Medical Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 42257 issued to Alok K. Bhattacharyya, M.D.;

2. Ordering Alok K. Bhattacharyya, M.D. to pay the division the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

3. Prohibiting respondent from supervising physician's assistants

4. Taking such other and further action as deemed necessary and proper.

DATED: January 29, 2003.

RONALD JOSEPH
Executive Director
Medical Board of California

State of California
Complainant